Myths and Truths
About Smoking Cessation Treatment
with Mental Health Populations

Myth: **My patients aren't interested in quitting.**

Truth: **Your mental health patients appreciate your smoking cessation treatment efforts!**

- An overwhelming majority of American smokers report that they not only want to quit, but also that they would attempt to quit if one of their health care providers simply recommended it.
- This is even true for people who are enrolled in mental health treatment—for instance, about 75% of adults in treatment for alcoholism are interested in smoking cessation treatment.

Myth: **Smoking cessation treatment is time-consuming and ineffective.**

Truth: **Smoking cessation treatment is easy and effective.**

- In fact, research shows that clinical interventions *as simple as recommending tobacco cessation* and *as short as three minutes* significantly increase abstinence rates.
- And while it is true that mental health patients sometimes have a harder time quitting than other populations, research suggests that mental health patients are *most likely* to succeed at quitting when smoking cessation treatment is delivered by their primary mental health providers.

Myth: **My patients should expect excessive weight gain if they quit smoking.**

Truth: **The average post-cessation weight gain is very small—around 6 pounds.**

- Moreover, a patient would have to gain an excess of 100 additional pounds to suffer the same health risks as they would if they continued smoking.
- It is thought that this small post-cessation weight gain is caused by a temporary increase in caloric intake and a temporary destabilization of normal metabolism. Your patients can therefore return to their baseline weight after sustained abstinence because caloric intake and metabolism tend to stabilize as time goes on.
- When working with patients who are concerned about post-cessation weight gain, do *not* recommend restrictive dieting. This often backfires because the unpleasantness of dieting can become associated with the healthy act of smoking cessation (thereby decreasing motivation for tobacco cessation). Instead, consider recommending a healthy increase in activity level. Bupropion and nicotine gum can also be considered because they have been shown to delay weight gain.

Myth: **I shouldn't encourage my patients to quit because they will invariably experience increased distress.**

Truth: **In actuality, patients can expect increased self-confidence and physical stamina as a result of abstinence, both of which allow them to engage in more healthy coping skills necessary to successful mental health treatment.**

●Consider that smokers actually have *much higher* anxiety, panic, and stress levels than non-smokers, as well as worse depression and poorer sleep (all because of the stimulant features of nicotine and related withdrawal symptoms).
●Moreover, smoke-free living can result in decreased social ostracism and isolation secondary to smoking behaviors and associated hygiene-deficits (e.g., body odor).
●While studies have found that a *minority* of patients with a history of major depression are more likely to report depressive symptoms after quitting than other populations, good treatment planning can help prevent increased distress.
●For instance, all patients who are planning to quit should be encouraged to set up extra support and daily exercise, both of which increase the likelihood of successful smoking cessation and are known to improve mood. Providers can also consider adjunctive pharmacotherapies: Bupropion is an FDA approved first-line treatment for both smoking cessation and depression, and Nortriptyline is an FDA approved first-line treatment for depression and a second-line treatment for smoking cessation.

Myth: **I shouldn't encourage my patients to quit because they will be at higher risk of relapse to other drugs or alcohol.**

Truth: **Research indicates that quitting smoking can actually *improve* abstinence from other substances.**

●In addition, smokers with a history of co-occurring addictions are just as likely to successfully quit smoking as people without co-occurring addictions.

Myth: **Smoking with my patients is therapeutic.**

Truth: **Taking smoking-breaks with patients promotes the idea that substance abuse is a healthy way to establish supportive relationships**.

●Similarly, scheduled smoking breaks promote reliance on unhealthy coping strategies to manage boredom and stress.
●Instead of smoking breaks, providers can schedule 'walking-breaks' or simple 'fresh air breaks' to increase rapport, relieve patient boredom, and increase patient socialization.

Please contact your nearest National Preceptor
if you would like more information on brief smoking cessation treatment with mental health patients.